		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044313

Facility Name: Cardinal Health Care

Address: 210 East College (Number) Energy (City) 62933 (Zip Code)

County: Williamson

Telephone Number: (618) 942-7014 **Fax #** 618) 942-7196

IDPA ID Number: 37-1377445002

Date of Initial License for Current Owners: 06/09/1999

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Neil R. Thompson **Telephone Number:** (630) 783-0529

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Ronald A. Hunter
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Neil R. Thompson, Certified Public Accountant
(Firm Name & Address) Neil R. Thompson, CPA, 656 Anne Court, Bolingbrook, Illinois 60440
(Telephone) (630) 783-0529 Fax # (630) 783-0529

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/1/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	96		3
4	73	Intermediate/DD	63		4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159		7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	23,876	1,454		25,330	10
11	ICF/DD	11,046			11,046	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,922	1,454		36,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) _____

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 9/30/2002 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	166,024		16,208	182,232		182,232		182,232			1
2	Food Purchase		156,903		156,903		156,903		156,903			2
3	Housekeeping	103,428	23,751		127,179		127,179		127,179			3
4	Laundry	66,765	6,630		73,395		73,395		73,395			4
5	Heat and Other Utilities			115,435	115,435		115,435		115,435			5
6	Maintenance	19,861	6,100	53,632	79,593		79,593		79,593			6
7	Other (specify):*											7
8	**TOTAL General Services**	356,078	193,384	185,275	734,737		734,737		734,737			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,624,934	50,244	24,952	1,700,130		1,700,130		1,700,130			10
10a	Therapy			5,129	5,129		5,129		5,129			10a
11	Activities	76,575	1,630		78,205		78,205		78,205			11
12	Social Services	64,174		7,992	72,166		72,166		72,166			12
13	Nurse Aide Training	21,132		350	21,482		21,482		21,482			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,786,815	51,874	48,023	1,886,712		1,886,712		1,886,712			16
	C. General Administration											
17	Administrative	143,074			143,074		143,074		143,074			17
18	Directors Fees											18
19	Professional Services			43,286	43,286		43,286		43,286			19
20	Dues, Fees, Subscriptions & Promotions			2,571	2,571		2,571		2,571			20
21	Clerical & General Office Expenses	70,397	17,297	32,736	120,430		120,430		120,430			21
22	Employee Benefits & Payroll Taxes			369,599	369,599		369,599		369,599			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,864	8,864		8,864		8,864			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,760	32,760		32,760		32,760			26
27	Other (specify):*											27
28	**TOTAL General Administration**	213,471	17,297	489,816	720,584		720,584		720,584			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,356,364	262,555	723,114	3,342,033		3,342,033		3,342,033			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Cardinal Health Care #0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.			200	200		200		200			31
32	Interest			3,285	3,285		3,285		3,285			32
33	Real Estate Taxes			48,412	48,412		48,412		48,412			33
34	Rent-Facility & Grounds			195,000	195,000		195,000		195,000			34
35	Rent-Equipment & Vehicles			23,321	23,321		23,321	(5,000)	18,321			35
36	Other (specify):* DEPRECIATION			41,240	41,240		41,240		41,240			36
37	**TOTAL Ownership**			311,458	311,458		311,458	(5,000)	306,458			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			27,014	27,014		27,014		27,014			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,291	87,291		87,291		87,291			42
43	Other (specify):* DISALLOWED COSTS			32,296	32,296		32,296	(28,992)	3,304			43
44	**TOTAL Special Cost Centers**			146,601	146,601		146,601	(28,992)	117,609			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,356,364	262,555	1,181,173	3,800,092		3,800,092	(33,992)	3,766,100			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,463)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,377)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,430)	43		18
19	Entertainment				19
20	Contributions	(48)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(525)	43		24
25	Fund Raising, Advertising and Promotional	(149)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,992)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(3,304)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (3,304)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (32,296)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Cardinal Health Care

ID# 0044313

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (889)	29	1
2	LATE CHARGES	(1,077)	29	2
3	RESIDENT PROPERTY REPLACEMENT	(75)	29	3
4	RESIDENT MEDICAL/DENTAL	(1,263)	29	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,304)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cardinal Health Care # 0044313 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cardinal Health Care # 0044313 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(28,992)	0	0	0	0	0	0	0	0	0	0	(28,992)	43
44	**TOTAL Special Cost Centers**	(28,992)	0	0	0	0	0	0	0	0	0	0	(28,992)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,992)	0	0	0	0	0	0	0	0	0	0	(28,992)	45

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
RONALD A . HUNTER	100.00	CARDINAL HILL HEALTHCARE, LLC	GREENVILLE, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	RONALD A. HUNTER	PRESIDENT	ADMINISTRATIV	100.00	65,000	40+	60.00		$ 67,687	17-1	1
2	VERONICA SCHRAER	VP OF OPERATION	ADMINISTRATIV	0.00	0	40	100.00		37,926	17-1	2
3	KEVIN SCHRAER	ADMINISTRATOR	ADMINISTRATIV	0.00	0	40	100.00		37,461	17-1	3
4	BENJAMIN HUNTER	MAINTENANCE	MAINTENANCE	0.00	32,720	0	0.00			N/A	4
5	EDGAR HUNTER	MAINTENANCE	MAINTENANCE	0.00	32,720	0	0.00			N/A	5
6	CYNTHIA HUNTER	ADMINISTRATOR	ADMINISTRATIV	0.00	26,951	0	0.00			N/A	6
7	STORMY HUNTER	OFFICE CLERK	CLERICAL	0.00	8,201	0	0.00				7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,074		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FINANCIAL PACIFIC LEASING		X	LEASE OBLIGATION	$567.00	01/01/99	$ 13,719	$ 2,716	04/01/03	0.3882	$ 1,903	1
2	TELMARK		X	LEASE OBLIGATION	$309.00	08/01/99	10,650	1,726	05/01/03	0.1931	704	2
3	ALLIANCE LAUNDRY SYSTEMS		X	LEASE OBLIGATION	$285.00	01/02/00	10,317	3,161	11/01/03	0.1450	678	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	NONE	6/28/99	190,000		06/28/02	0.0825		6
7	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	NONE	6/28/99	75,000		06/28/02	0.0825		7
8												8
9	TOTAL Facility Related				$1,161.00		$ 299,686	$ 7,603			$ 3,285	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 299,686	$ 7,603			$ 3,285	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ NONE** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Cardinal Health Care # 0044313 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	103,519	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(103,519)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	151,931	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	48,412	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	53,435	8
	1998	57,130	9
	1999	57,535	10
	2000	46,019	11
	2001	48,412	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cardinal Health Care COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0044313

CONTACT PERSON REGARDING THIS REPORT NEIL R. THOMPSON

TELEPHONE 630-783-0529 FAX #: 630-783-0529

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-227-019	W 435.6 OF E 780 OF S 500 OF N52(	$ 48,412.00	$ 48,412.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,412.00	$ 48,412.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,850 B. General Construction Type: Exterior BRICK VENEER Frame MASONRY BLOCK Number of Stories ONE

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 1,000
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 200
4. Dates Incurred: 1999

Nature of Costs: INCORPORATION FEES
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof repairs			1999	5,250	350	15	350		1,225	9
10	A-Wing renovations			1999	7,008	467	15	467		1,635	10
11	C-Wing renovations			1999	510	34	15	34		119	11
12	Laundry building renovations			1999	31,280	2,085	15	2,085		7,298	12
13	Landscaping-garden area			1999	5,225	348	15	348		1,218	13
14	A-Wing renovations			1999	144,174	9,612	15	9,612		33,642	14
15	C-Wing renovations			1999	61,734	4,116	15	4,116		14,406	15
16	Architectural services for A-Wing and C-Wing renovations			1999	4,610	307	15	307		1,075	16
17	Security system for A-Wing, B-Wing, C-Wing			1999	31,221	2,081	15	2,081		7,284	17
18											18
19	A-Wing renovations completed			2000	10,261	684	15	684		1,710	19
20	C-Wing renovations completed			2000	42,155	2,810	15	2,810		7,025	20
21											21
22	Laundry building renovations			2001	916	61	15	61		92	22
23	Dumpster area improvements			2001	528	35	15	35		53	23
24	A-Wing renovations			2001	56,214	3,748	15	3,748		5,622	24
25	Parking lot and driveway improvements			2001	2,950	197	15	197		295	25
26	Architectural services for A-Wing renovations			2001	5,067	338	15	338		507	26
27											27
28	Hot water heater for A-Wing kitchen			2002	184	6	15	6		6	28
29	Wall heating/cooling units for A-Wing and C-Wing			2002	4,301	143	15	143		143	29
30	C-Wing renovations			2002	40,700	1,357	15	1,357		1,357	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 454,288	$ 28,780		$ 28,780	$	$ 84,713	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 97,880	$ 9,788	$ 9,788	$	10	$ 25,943	71
72	Current Year Purchases	10,065	503	503		10	503	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 107,945	$ 10,291	$ 10,291	$		$ 26,446	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van	1999	$ 10,843	$ 2,169	$ 2,169	$	5	$ 7,591	76
77										77
78										78
79										79
80	TOTALS			$ 10,843	$ 2,169	$ 2,169	$		$ 7,591	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 573,076	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,240	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 41,240	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 118,750	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	159		$ 195,000	20	NONE	3
4	Additions							4
5								5
6								6
7	TOTAL		159		$ 195,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. NONE
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [X] YES [ ] NO Terms: SEE ATTACHMENT *

10. Effective dates of current rental agreement:
Beginning 10/01/1998
Ending 09/30/2018

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$ 255,000
13.	12/31/2004	$ 255,000
14.	12/31/2005	$ 255,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 16,708 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RESIDENT CARE	VAN	$ 769.00	$ 1,613	17
18	MANAGEMENT USE	SUV	999.00	5,000	18
19					19
20	LESS:NON-ALLOWABLE LEASE EXPENSE			(5,000)	20
21	TOTAL		$ 1,768.00	$ 1,613	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		350		350
3	Classroom Wages (a)		10,521		10,521
4	Clinical Wages (b)		4,676		4,676
5	In-House Trainer Wages (c)		5,935		5,935
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 21,482	$	$ 21,482
10	SUM OF line 9, col. 1 and 2 (e)	$ 21,482			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		38	2,275		38	2,275	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				12,384		12,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): OXYGEN	39(2)					14,630		14,630	13
14	TOTAL			$		$ 2,275	$ 27,014	38	$ 29,289	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Cardinal Health Care # 0044313 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,962	$ 4,962	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	487,511	487,511	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	49,398	49,398	8
9	Other(specify): SEE ATTACHED SCHEDULE	585,455	585,455	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,127,326	$ 1,127,326	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	454,287	454,287	15
16	Equipment, at Historical Cost	118,787	118,787	16
17	Accumulated Depreciation (book methods)	(118,750)	(118,750)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,000	1,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(833)	(833)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 454,491	$ 454,491	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,581,817	$ 1,581,817	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 331,065	$ 331,065	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,280	61,280	30
31	Accrued Taxes Payable (excluding real estate taxes)	764,792	764,792	31
32	Accrued Real Estate Taxes(Sch.IX-B)	151,931	151,931	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED SCHEDULE	2,537,266	2,537,266	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,846,334	$ 3,846,334	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,603	7,603	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,603	$ 7,603	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,853,937	$ 3,853,937	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,272,120)	$ (2,272,120)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,581,817	$ 1,581,817	48

***(See instructions.)**

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,755,925)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADUSTMENTS SUBSEQUENT TO COST		3
4	REPORT PREPARATION	628	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,755,297)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(516,823)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (516,823)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,272,120)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,093,622	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,093,622	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DEBT FORGIVENESS INCOME	185,743	28
28a	MISCELLANEOUS INCOME	3,904	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 189,647	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,283,269	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	734,737	31
32	Health Care	1,886,712	32
33	General Administration	720,584	33
	B. Capital Expense		
34	Ownership	311,458	34
	C. Ancillary Expense		
35	Special Cost Centers	27,014	35
36	Provider Participation Fee	87,291	36
	D. Other Expenses (specify):		
37	DISALLOWED COSTS	32,296	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,800,092	40
41	**Income before Income Taxes (line 30 minus line 40)****	(516,823)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (516,823)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,053	2,086	$ 38,669	$ 18.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,305	13,668	231,727	16.95	3
4	Licensed Practical Nurses	21,153	21,702	277,072	12.77	4
5	Nurse Aides & Orderlies	52,232	53,876	442,436	8.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,782	3,939	35,103	8.91	8
9	Activity Director	2,021	2,046	18,000	8.80	9
10	Activity Assistants	6,936	7,181	58,575	8.16	10
11	Social Service Workers	5,250	5,379	64,174	11.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,959	23,928	166,024	6.94	15
16	Dishwashers					16
17	Maintenance Workers	2,134	2,204	19,861	9.01	17
18	Housekeepers	15,472	16,016	103,428	6.46	18
19	Laundry	11,869	12,352	66,765	5.41	19
20	Administrator	2,045	2,086	37,926	18.18	20
21	Assistant Administrator					21
22	Other Administrative	4,102	4,252	105,148	24.73	22
23	Office Manager	2,024	2,248	17,981	8.00	23
24	Clerical	4,148	4,307	52,418	12.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,842	5,143	67,728	13.17	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	58,633	60,732	503,836	8.30	30
31	Medical Records	3,336	3,442	28,361	8.24	31
32	Other Health Care(specify)					32
33	Other(specify)	2,210	2,210	21,132	9.56	33
34	TOTAL (lines 1 - 33)	240,506	248,797	$ 2,356,364 *	$ 9.47	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	181	$ 6,819	1(3)	35
36	Medical Director	MONTHLY	9,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	140	13,283	10(3)	38
39	Pharmacist Consultant		4,837	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	160	7,992	12(3)	45
46	Other(specify)				46
47	PSYCHIATRIC CONSULTANT	74	3,675	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	554	$ 46,206		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEVIN SCHRAER	ADMINISTRATOR	0	$ 37,926
RONALD A HUNTER	ADMINISTRATIVE	100.00	67,687
VERONICA HUNTER	VP OPERATIONS	0	37,461
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,074

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NEIL R. THOMPSON	ACCOUNTING	$ 29,575
AMERICAN EXPRESS TAX	ACCOUNTING	6,205
HENDRICK AND HAGAN	LEGAL	6,071
HENNINGSON & SNOXELL	LEGAL	1,185
STRATTON, GIGANTI, STONE	LEGAL	250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 43,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,000
Unemployment Compensation Insurance	86,918
FICA Taxes	176,982
Employee Health Insurance	31,685
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
AWARDS AND OTHER BENEFITS	5,918
EMPLOYEE BACKGROUND CHECK	1,800
EMPLOYEE DRUG TESTING	1,296
TOTAL (agree to Schedule V, line 22, col.8)	$ 369,599

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,251
Health Care Worker Background Check	
(Indicate # of checks performed)	
MISCELLANEOUS DUES	320
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,571

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
STAFF MILEAGE	8,334
Seminar Expense	530
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,864

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Cardinal Health Care # 0044313 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	NONE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,500** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,291**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **83**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

CARDINAL HEALTH CARE, INC.
FACILITY#: 0044313
01/01/2002-12/31/2002

PAGE 14 - RENTAL COSTS - LINE 9 - OPTION TO BUY
TERMS OF OPTION:

OPTION PRICE	$ 2,400,000
OPTION DATE	ANY TIME AFTER 9/30/2003

PAGE 14 - MOVEABLE EQUIPMENT LEASE COSTS - LINE 16

TRAPEZE BARS	392
OXYGENATORS	1,982
DISHWASHERS	982
SECURITY SYSTEM	2,831
BOBCAT MOVING EQUIPMENT	1,055
TIME CLOCK	1,531
TELEPHONE SYSTEM	4,927
COPIERS	3,008
	16,708

PAGE 17 - BALANCE SHEET - LINE 9 - OTHER CURRENT ASSETS:

DUE FROM LAKELAND HEALTH CARE	115,792
DEPOSITS	1,067
EMPLOYEE ADVANCES AND LOAND	44,345
DUE TO/FROM AFFILIATED COMPANIES	424,251
	585,455

PAGE 17 - BALANCE SHEET - LINE 36 - OTHER CURRENT LIABILITIES:

CASH OVERDRAFT	491,333
ACCRUED PROVIDER FEE	143,033
ACCRUED RENT PAYABLE	554,900
ADVANCES FROM LESSOR	1,348,000
	2,537,266

PAGE 20: STAFFING & SALARY COSTS -

LINE 32 - OTHER HEALLTH CARE STAFF	HOURS WORKED	HOURS PAID	WAGES	AVE. HRLY WAGE
STAFF TRAINING FOR HABILITATION AIDS	1,820	1,820	15,197	8.35
STAFF TRAINER FOR HABILITATION AIDS	390	390	5,935	15.22
	2,210	2,210	21,132	9.56

PAGE 4 - LINE 45 - TOTAL ADJUSTMENTS:

		REFERENCE
PERSONAL USAGE OF VEHICLE RENTALS	5,000	35(7)
CABLE TV COSTS	14,463	43(7)
PERSONAL TRAVEL COSTS AND AUTO RELATED EXPENSES	10,377	43(7)
FINES AND PENALTIES	3,430	43(7)
CONTRIBUTIONS	48	43(7)
BAD DEBTS	525	43(7)
PRINT ADVERTISING	149	43(7)
BANK CHARGES	889	43(7)
LATE CHARGES	1,077	43(7)
RESIDENT PROPERTY REPLACEMENT	75	43(7)
RESIDENT MEDICAL/DENTAL	1,263	43(7)
TOTAL ADJUSTMENTS FOR NON-ALLOWABLE COSTS	37,296	

PAGE 19 - LINE 28 - OTHER REVENUE:

MISCELLANEOUS INCOME	3,904
	3,904